Summary of Changes to H.R. 2473
Made by Chairman's Amendment in the Nature of a Substitute
Markup of the "Medicare Prescription Drug and Modernization Act of 2003"

Title	*Section*	*Page*	*Explanation of Change*
I	1860D-1	8	Changes date on line 18 from November to October.
I	1860D-1	9	On line 29, clarifies no additional premium applies if a beneficiary enrolls in a plan when first eligible.
I	1860D-1	10	Beginning on line 18, conforms section to change added on page 9.
I	1860D-2	15	Changes copayments to coinsurance to reflect the nature of beneficiary cost sharing.
I	1860D-2	16	Lowers catastrophic threshold from $3,700 to $3,500.
I	1860D-2	16	Allows state pharmaceutical assistance plan spending to "wrap" or count their spending against an individual's out-of-pocket spending in calculating their catastrophic benefit.
I	1860D-2	18	Provides for the Medicare Ombudsman offering assistance to enrollees in presenting more recent income information and the toll free number being the contact for beneficiaries to inquire as to how information is being presented.
I	1860D-2	26	Insert "specific" after "access to."
I	1860D-2	28	Line 35, insert "independent and free from conflict with respect to the committee and."

I	1860D-2	29	Strikes “clinical bases for coverage of any drug on” and inserts “bases for the exclusion of coverage of any drug from.”
I	1860D-3	29	On lines 31 to 34, requires plans to notify beneficiaries when a change has been made in the preferred status of a drug or biological or a change in beneficiary coinsurance.
I	1860D-3	30	Adds in (d) a requirement to include consideration of side effects in developing quality assurance measures.
I	1860D-4	35	Clarifies that the external review applies to tier copay appeals as well as for drugs off formularies.
I	1860D-4	38	Adds on lines 8 and 15 EFFS plans to reflect their inclusion in the limit on administrative fees.
I	1860D-4	38	On line 29, clarifies drug plan regions should be consistent with EFFS regions.
I	1860D-6	44	Makes technical change on line 27 to include EFFS plans in addition to MA plans.
I	1860D-7	47	Indexes the low-income prescription drug subsidy asset test, starting at two times the SSI asset test.
I	1860D-8	51	Changes subsidy from 72% to 73% and direct subsidy from 42% to 43%.
I	1860D-8	53	Ensures discounts and chargebacks are not counted as part of allowable costs.

I	1860D-8	53	On line 34, defines qualified individual for purposes of reinsurance.
I	1860D-8	57	Clarifies qualified individual on page 16 as someone enrolled in a qualified retiree prescription drug plan.
I	1860D-8	57	Clarifies that employer supplemental coverage offered to a retiree who is enrolled in a prescription drug plan or MA-EFFS plan is primary payor.
I	104	74	Makes clear on line 8 that beneficiaries with existing Medigap policies will be allowed to continue those policies regardless of the new benefit.
I	105	80	Appropriates $2 billion in 2003 and $3 billion in 2004 for immediate low-income assistance program through the prescription drug card.
II	201	85	Requires the Administrator to conduct a market survey and analysis to determine how regions should be established and rural areas covered.
II	212	96	Funds the blend and adds DoD-Va services in 2004.
II	236	113	Extends Municipal Health Service demonstrations.

II	241	113	Provides for the following modifications to section 241: • Requires area private plan market share to at least equal national private plan market share to trigger transition to competitive benchmark; • Provides for 5-year phase-in from EFFS-MA benchmark to competitive benchmark; and, • Limits premium changes for fee for service Medicare through 5-year phase-in.
III	303	135	Changes to the physician fee schedule apply in 2005 and any physician specialty may submit data for that would be budget neutral for 2004.
III	303	144	Includes replenishment of a physician's inventory.
III	303	137	Allows physicians choice of contractor model or average sales price net of rebates and discounts. Makes conforming changes throughout section to make application.
IV	410	168	Narrows provision for increase for rural low volume ambulances to the lowest 25% of Medicare populated areas.
IV	411	169	Expands the one-year bonus for home health increases to two years.
IV	415	172	Extends telemedicine demonstration program.
VI	602	183	Adds study on Medicare payments for inhalation therapy.

VI	603	183	Includes study on volume of physician services.
VI	622	195	Revises study to include an examination of how costs differ among the types of ambulance providers.
VI	629	201	Extension of IVIG for primary immune diseases in the home.
VII	723	219	Removes requirement that coverage criteria be done by regulation with requirement that they make it available to the public.
VII	723	220	Includes coding in the extension of the time frames from BIPA.
VII	724	222	Changes provision to continue independent billing for pathology services for both inpatient and hospital outpatient services for 5 years.
VIII	801	224-5	Changes term of Administrator and Chief Administrator from 5 years to 4 years.
VII	801	228	Adds the following exceptions from Chapter 31, Title 5: 3102-3108, 3111, 3113, 3136, 3151.
IX	942	310	Inserts a provision to allow the Secretary of Health and Human Services to adopt the ICD-10 as a standard, regardless of whether the National Committee on Vital and Health Statistics has made a recommendation regarding the standard.
IX	944	313	Allows exception for screening for patients asking for prescription refills, blood pressure screening and non-emergency tests.

IX	954	321	Includes temporary suspension of OASIS data for non-Medicare, non-Medicaid patients until publication of final rule on the collection and use of OASIS data.